

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

*Quality Assurance Division-Licensure Bureau
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953
FAX: (406) 444-1742*

**ASSISTED LIVING FACILITY LICENSE APPLICATION:
CATEGORY B SUPPLEMENTAL REQUIREMENTS**

Category B facilities must meet all Category A requirements

***IF A NEW FACILITY OR CHANGES HAVE OCCURRED SINCE INITIALLY LICENSED
PLEASE INCLUDE COMPLETED CATEGORY A APPLICATION WITH THIS APPLICATION***

Facility Name:

Facility Address: PO Box:

City/State: Zip:

Facility Telephone Number: FAX:

Facility E-mail/Web page Address:

*Name of health care provider or agency performing on-site assessments, certification of care level and health care plan:

*** A Category B license will not be issued without this information. The provider must be an RN or higher level of professional clinician.**

Please submit the following:

☐ Verification that the administrator has met the requirements for Assisted Living Administration ***and*** has one or more years experience working in the field of geriatrics or caring for disabled residents in a licensed facility.

☐ Category B policy and procedures.

Application for a Category B Assisted Living Facility license is hereby submitted under the provision of Section 50-5-101 through 50-5-228. (See attached)

SIGNED _____ DATE _____

TITLE _____

ADDRESS: _____

CITY _____ STATE/ZIP _____